

Required Gold Orchestra Health Form Please print. Return by September 3, 2004.

This information is read only by a health official and only if there is a possibility of treatment.

Child's Name _____ Age on 10/01/04 _____

Parent or Guardian _____

Address _____ Manhattan KS 6650 _____

In Case of Emergency, Notify: _____

Home Phone (785) _____ Work Phone (785) _____

Relationship to Student _____

Is your child covered by medical-surgical-hospital insurance? Yes No

Name of Insurance Co. _____

Policy No. _____ Name of Subscriber _____

Individual (self-pay) Policy # _____ OR Group Insurance # _____

If group, through what organization? _____

Health History Check those that apply.

Diseases

- Chicken Pox
- Measles
- German Measles
- Mumps

Allergies

- Animals
- Plants
- Insect Stings
- Medicine /Drugs _____
- Food _____
- Pollen Hay Fever Other _____

Chronic or Recurring Illness

- Ear Infections
- Heart Defect/Disease
- Seizures
- Bleeding Disorders
- Asthma
- Hypertension
- Diabetes
- Musculo-skeletal Disorders
- Other (Specify) _____

Other

- Fainting
- Sleep disturbance
- Emotional disturbance
- Menstrual cramps
- Nosebleeds
- Constipation

Please describe conditions and give dates: Other diseases/disabilities _____

Any other health information you think would be helpful: _____

Specific medical or dietary regimen to be followed (specify) _____

Is your child taking medicine regularly? Yes No

What medication? _____ How often? _____

Will he/she be taking this medicine on the trips? Yes No

Do you give the adults in charge permission to be in charge of dispensing any medicine? Yes No

What medicine do you permit your child to take for a headache? _____

This health history is correct and my son/daughter has permission to engage in all prescribed activities, except as noted by me. I give my permission for accompanying chaperones to seek emergency first aid treatment during the trip to Rock Springs 4-H Ranch (October 22-24, 2004) and any other Gold Orchestra event.

I authorize any physician or physicians to administer any treatment or to administer such drugs and anesthetics as may be deemed necessary or advisable in the treatment of my son/daughter. This authorization is effective through March 31, 2005.

Signature of Parent/Guardian Date _____

Signature of Parent/Guardian

It is **not** necessary to have a Public Notary witness the signature.